STATEMENT OF
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THE AMERICAN LEGION
BEFORE A
JOINT SESSION OF THE
VETERANS' AFFAIRS COMMITTEES
UNITED STATES CONGRESS
ON THE
LEGISLATIVE PRIORITIES OF THE AMERICAN LEGION

SEPTEMBER 21, 2004

Messrs. Chairmen and Members of the Committees:

As The American Legion's newly elected National Commander, I thank you for this opportunity to present the views of its 2.7 million members on issues under the jurisdiction of your Committees. At the conclusion of The American Legion's Eighty-Sixth National Convention in Nashville, Tennessee, over 4,000 delegates adopted 212 organizational resolutions with 158 having legislative intent. These organizational mandates will form the legislative portfolio of The American Legion for the 109th Congress.

As Legionnaires gathered at our National Convention to once again determine the path of the nation's largest veterans' service organization, it was with respect for those who have worn the uniform before us, friendship for those with whom we served and admiration for those who currently defend the freedoms of this great nation. Each generation of America's veterans has earned the right to quality health care and transitional programs available through the Department of Veterans Affairs (VA). The American Legion will continue to work with both Committees to ensure that VA is indeed capable of providing "care for him who shall have borne the battle and for his widow and his orphan."

With young American service members continuing to answer the nation's call to arms in every corner of the globe, we must now, more than ever, work together to honor their sacrifices. Those men and women who return from battle with career ending injuries and life changing memories will turn to VA for their health care; health care they have earned through their service to this country. VA must be funded at levels that will ensure that all enrolled eligible veterans receive quality health care in a timely manner.

With that in mind and on behalf of The American Legion, I offer the following budgetary recommendations for the Department of Veterans Affairs (VA) for FY 2006:

BUDGET PROPOSALS FOR SELECTED DISCRETIONARY PROGRAMS FOR DEPARTMENT OF VETERANS AFFAIRS FOR FISCAL YEAR 2006

Program	VA FY 2004 Funding	VA FY 2005 Request	Legion's FY 2006 Request
Medical Care ***Including:***	$26.5 billion	$29.5 billion	$31.5 billion
• *Medical Services*		*$19.5 billion*	
• *Medical Administration*		*$4.7 billion*	
• *Medical Facilities*		*$3.7 billion*	
• *Medical Care Collections*	*$1.8 billion (Offset)*	*$2.4 billion (Offset)*	Supplement*
Medical & Prosthetics Research	$406 million	$385 million	$447 million
Construction			
• Major	$214 million	$401 million	$327 million
o CARES			$1 billion
• Minor	$205 million	$182 million	$261 million
State Extended Care Facilities	$102 million	$105 million	$124 million
State Veterans' Cemeteries	$32 million	$32 million	$42 million
NCA	$143 million	$274 million	$274 million
General Administration	$1.3 billion	$1.2 billion	$1.8 billion

The American Legion recommends $31.5 billion for Medical Care in FY 2006.

* Third-party reimbursements should supplement rather than offset discretionary funding.

VETERANS HEALTH ADMINISTRATION

Access To Medical Care

Today, there are nearly 26 million veterans. As more veterans choose to use VA as their primary health care provider (over 8 million veterans enrolled or waiting to enroll), the strain on the system continues to grow. The American Legion fully supported the enactment of Public Law (PL) 104-262, the Veteran's Healthcare Eligibility Reform Act that opened enrollment in the VA health care system. Many veterans who, until 1996, were ineligible for VA health care are now able to enroll. Veterans recognize that VHA provides affordable, quality care that they cannot receive anywhere else.

Reinstatement Of Priority Group 8 Veterans

The astronomical growth of Priority Groups 7 and 8 veterans seeking health care at their local VA medical facility has resulted in over 300,000 veterans being placed on waiting lists regardless of their assigned Priority Group. FY 2004 saw the continuation of suspension of enrollment of new Priority Group 8 veterans due to the increased demands for services. The American Legion does not agree with the decision to deny health care to veterans simply to ease the backlog. Denying earned benefits to eligible veterans does not solve the problems resulting from an inadequate budget.

In passing the Veterans' Health Care Eligibility Reform Act of 1996, PL 104-262, Congress required VA to furnish hospital care and medical services to, among others, any veteran with a compensable service-connected disability or who is unable to defray the expenses of necessary medical care and services. It further authorized the VA, with respect to veterans not otherwise eligible for such care and services, to furnish needed hospital, medical, and nursing home care.

The overwhelming response from the veteran population was largely unanticipated and drastically under funded, leading to an unprecedented backlog of veterans waiting to receive care at VA. In an effort to reduce that backlog, VA Secretary Anthony Principi suspended enrollment of new Priority Group 8 veterans. The American Legion strongly opposes this decision and calls for the reinstatement of enrollment for Priority Group 8 veterans.

Mandatory Funding For Veterans Health Care

A new generation of young Americans is once again deployed around the world, answering our nation's call to arms. Like so many brave men and women who honorably served before them, these new veterans are fighting for the freedom, liberty and security of us all. Also like those who fought before them, today's veterans deserve the due respect of a grateful nation when they return home.

Unfortunately, without urgent changes in health care funding, new veterans will soon discover their battles are not over. They will be forced to fight for the life of a health care system that was

designed specifically for their unique needs, just as the veterans of the 20th century did, they will be forced to fight for the care they each are eligible to receive.

The American Legion believes that the solution to the Veterans Health Administration (VHA) recurring fiscal difficulties will only be achieved when its funding becomes a mandatory spending item. Funding for VA health care currently falls under discretionary spending within the Federal budget. VA's health care budget competes with other agencies and programs for Federal dollars each year. The funding requirements of health care for service-disabled veterans are not guaranteed under discretionary spending. VA's ability to treat veterans with service-connected injuries is dependent upon discretionary funding approval from Congress each year.

Under mandatory funding, however, VA health care would be funded by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care entitlement of enrolled veterans.

The American Legion is pleased to support legislation that would establish a system of capitation-based funding for VHA by combining the total enrolled veteran population with the number of non-veterans who received services from VHA, then dividing that number into 120 percent of the current VHA budget. This baseline per-capita amount is then adjusted for medical inflation each year and is multiplied by the veteran and non-veteran population for the prior fiscal year to arrive at a total budget for VHA for each succeeding fiscal year. This new funding system would provide all of VHA's funding, except funding of the State Veterans Homes Construction Grant Program, which would be separately authorized. Annual funding would be without fiscal year limitation, meaning that any savings VHA realized in a fiscal year would be retained rather than returned to the Treasury, providing VHA with incentives to develop efficiencies and creating a pool of funds for enhanced services, needed capital improvements, expanded research and development and other purposes.

The Veterans Health Administration is now struggling to maintain its global preeminence in 21st century health care with funding methods that were developed in the 19th century. No other modern health care organization could be expected to survive under such a system. The American Legion believes that health care rationing for veterans must end. It is time to guarantee health care funding for all veterans.

Medical Care Collection Fund

PL 105-33, the Balanced Budget Act of 1997, established the VA Medical Care Collections Fund (MCCF), requiring that amounts collected or recovered from third party payers after June 30, 1997 be deposited into this fund. The MCCF is a depository for collections from third party insurance, outpatient prescription co-payments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the government. In fiscal year 2003, VHA collected $840 million, a significant increase over the $540 million collected in fiscal year 2001. The fiscal year 2004 budget estimate projects $1.7 billion in MCCF collections and the VA fiscal year 2005 budget request calls for an ambitious $2.3 billion to supplement appropriations.

Recent Government Accountability Office (GAO) reports have described continuing problems in VHA's ability to capture insurance data in a timely and correct manner and raised concerns about VHA's ability to maximize its third-party collections. At three medical centers visited, GAO found inability to verify insurance, accepting partial payment as full, inconsistent compliance with collections follow-up, insufficient documentation by VA physicians, insufficient automation and a shortage of qualified billing coders were key deficiencies contributing to the shortfalls. VA should implement all available remedies to maximize its collections.

Technically, the MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF treasury account, but remain within VHA and are used as operating funds. Instead, in developing a budget proposal, the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. We fail to see the difference in the net effect to the VISNs and VAMCs. Offsetting estimated MCCF funds largely defeats the purpose of realigning VHA's financial model to more closely approximate the private sector. The American Legion adamantly opposes offsetting annual VA discretionary funding by the MCCF recovery.

Private Third Party Reimbursement

Many veterans, especially those in Priority Groups 7 and 8, have private health insurance through employment and many of those veterans would choose VA as their primary health care provider were they able to do so. VHA is now authorized to bill most fee-for-service and point-of–service insurance carriers, such as Blue Cross/Blue Shield. Not so with Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). These payers simply reject VHA claims for reimbursement as "out of network." The American Legion supported legislation in the 108th Congress that would require HMOs and PPOs to consider Federal government agencies providing health care as network providers and pay claims at the usual and customary rate for the area where services are rendered.

Medicare

As do all working citizens, veterans pay into the Medicare system without choice. A portion of each earned dollar is allocated to the Medicare Trust Fund and although veterans must pay into the Medicare system they cannot use their Medicare benefits at any VA health care facility. VA cannot bill Medicare for the treatment of Medicare eligible veterans' nonservice-connected medical conditions. The American Legion does not agree with this policy and supports Medicare reimbursement for VHA for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans. As a Medicare provider, VHA would be authorized to bill and collect allowable third-party reimbursements from the Medicare Trust Fund for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans.

The Indian Health Service (IHS) Model

In 1976, Congress enacted the Indian Health Care Improvement Act amending Titles XIII (Medicare) and XIX (Medicaid) of the Social Security Act. This law allowed IHS to bill for medical services provided by IHS facilities to Native Americans eligible for Medicare Part A or Medicaid. Billing for Medicare Part B was authorized in 2001. IHS has had targeted goals for Medicare and Medicaid collections and is meeting those goals. The Indian Health Service's successful experience with Medicare and Medicaid demonstrates that a Federal agency can manage Centers for Medicare and Medicaid Services billing and collection. This creates a blueprint for similar collections by VA, when Medicare reimbursement is authorized.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

Over the past four years, The American Legion has carefully followed the progress of the Secretary of Veterans Affairs' Capital Asset Realignment for Enhanced Services (CARES) process. CARES has been an incredibly complex national process to reorganize VA through a data driven assessment of veterans' health care needs through the years 2012 and 2022. Unprecedented, CARES is the future of VA health care delivery of services that will, ostensibly, meet veterans' current and future health care needs. The American Legion has participated at each stage of the process by gathering information on VA Medical Centers throughout the country to make certain medical facilities were not closed simply to save money. We did this with the help of Legionnaires at both the Department and Post levels who care about the quality and timeliness of medical care for veterans. The American Legion expressed reservations about the planning model used in projecting long-term care, domiciliary, and outpatient mental health care needs into the future; these very important health care services were omitted from the CARES planning.

Secretary Principi has released his final CARES decisions and the implementation process is going forward. While The American Legion was not in total agreement with all the decisions made so far, we feel the process was fair due in large part to the hard work and input of The American Legion leadership, membership and national staff and that of numerous other stakeholders. As the implementation process continues, The American Legion is prepared to remain vigilant to assure that veterans are not deprived of their earned health care.

The CARES decision supports establishing new hospitals in three locations - Orlando, Las Vegas, and Denver. It also supports new bed towers in Tampa and San Juan, 156 new community clinics in 33 states and territories, a new multi-specialty outpatient clinic in Columbus, four new or expanded spinal cord injury centers and two new blind rehabilitation centers. Included in the plan is the closure of the Highland Drive (PA), Brecksville (OH) and Gulfport (MS) facilities.

The American Legion believes VA should exercise caution during the planning phases for these closures. No doors should be closed for services before new services are in place and functioning. Contingency planning needs to take place and stakeholders should be involved in all aspects of the implementation of these closures. During the CARES process, The American Legion took advantage of every opportunity, indeed created many, to ensure VA clearly understood the needs of local veterans. We believe this is a very important commitment to the veterans to whom VA provides services.

Through the CARES process over one hundred major construction projects were identified and submitted for review. VA prioritized these major capital investments through FY 2010. A plan of this magnitude requires a significant amount of resources to include trained and experienced personnel. This will have a major impact on VA's ability to move forward with the construction projects, even if they have the needed funding.

To successfully implement the CARES decision, VA has estimated that it will require an infusion of a $1 billion per year for the next six years, with continuing substantial infrastructure investments well into the future. The American Legion is opposed to the CARES funding coming out of the discretionary medical care account. The American Legion believes the CARES implementation must occur in the context of a fully utilized VA health care system. It must take into consideration VA's role in emergency preparedness, organizational capacity for "special emphasis programs" like mental health, long-term care, domiciliary and homeland security. Further, there must be continued oversight of the integration of the CARES process into the strategic planning process. Without that oversight, plans and promised services may be ignored.

Due to the sheer volume of work that CARES will be generating in the next two years, VA's Office of Facilities Management (OFM) has estimated that an additional 27 Resident Engineers will need to be hired to augment the 69 they already employ. Given that many of OFM's Resident Engineers will reach retirement eligibility during this period, VA should aggressively recruit, train and retain high-quality construction management talent.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT

Major Construction

Over the past several years, The American Legion has testified on the inadequacy of funding for VA's major and minor construction programs. This inadequacy has become even more apparent in light of the congressionally imposed moratorium on construction funding during the CARES process. The American Legion is both relieved and encouraged to see that the first two years worth of VA designated high-priority projects include critically needed seismic corrections to nine vulnerable structures in California and Puerto Rico. The American Legion has consistently expressed its concern that veterans are being placed in harm's way. There are over 60 patient care and other related use buildings in danger of collapse or heavy damage in the event of an earthquake. The sorely needed seismic corrections, along with the necessary ambulatory care and patient safety projects, will require a significant increase in funding to address VHA's current major construction requirements. We believe these designated seismic projects, other seismic corrections and life safety upgrades, should be dealt with first on an emergency basis.

VA's list of priority projects for fiscal years 2004 and 2005 will cost an estimated $1.36 billion. Of this, $942 million is from major construction and CARES appropriations, $400 million in transfer authority and nearly $60 million in prior year minor construction appropriations. The American Legion urges Congress to fully fund these requirements.

The American Legion recommends 1 billion for Major Construction in FY 2006.

Minor Construction

VA's minor construction program has likewise suffered significant neglect over the past several years. The requirement to maintain the infrastructure of VA's buildings is no small task. When combined with the added cost of the CARES program recommendations and the request for minor infrastructure upgrades in several research facilities, it is easy to see that a major increase over the previous funding level is crucial. We question the transfer of prior-year minor construction funds into CARES. During our site visits to some 60 VHA facilities over the past two years, we noted a recurrent theme in which facilities managers are routinely forced to divert funds from other priorities to repair roofs, replace boilers and upgrade utilities and life safety and other critical systems. The American Legion believes that these funds should be used for the purposes for which they were intended and that the "transfer authority" does not include monies designated for patient care.

The American Legion recommends $261 million for Minor Construction in FY 2006.

THE AGING OF AMERICA'S VETERANS

A landmark July 1984 study, *Caring for the Older Veteran*, predicted that a "wave" of elderly World War II and Korean Conflict veterans would occur some 20 years ahead of the elderly in the general U.S. population and had the potential to overwhelm the VA Long Term Care (LTC) system if not properly planned for. The most recent available data from VA, 2000 Census-based VETPOP2001Adjusted, shows there were 25.6 million veterans in 2002. Of that number, 9.76 million, or 37 percent are aged 65 or older. According to the 2001 National Survey of Veterans, the average age of all veterans was 58 years. More specifically, 21.1 percent of the veteran population was under the age of 45, 41.2 percent were between the ages of 45 and 64, and 37.1 percent of veterans were 65 years or older.

VA's Long Term Care Plan is Inadequate

The 1984 study recognized a " 'demographic imperative' that the rest of American society will confront in another 15 or 20 years (i.e., a burgeoning population of elderly persons needing both acute and long-term healthcare services)…." and that the "imminent need to provide a coherent and comprehensive approach to long-term care for veterans will severely strain the VA healthcare system and will require significant increased funding." Twenty years hence, the coherent and comprehensive approach called for has yet to materialize.

The Veterans Millennium Health Care and Benefits Act of 1999 provided VA authority to act on these projections. Based on an "aging in place" continuum of care model, VA was mandated to begin providing a variety of non-institutional services to aging veterans, including; home-based primary care, contract home health care, adult day health care, homemaker and home health aides, respite care, telehealth and geriatric evaluation and management.

On March 29, 2002, GAO issued a report that stated that nearly two years after The Millennium Act's passage, VA had not implemented its response to the requirements that all eligible veterans be offered adult day health care, respite care and geriatric evaluation. At the time of GAO's inquiry access to these services was "far from universal." While VA served about one-third of its 3rd Quarter 2001 LTC workload (23,205 out of an Average Daily Census of 68,238) in non-institutional settings, it only spent 8 percent of its LTC budget on these services. Additionally, VA had not even issued final regulations for non-institutional care, but was implementing the services by issuing internal policy directives, according to GAO. Of 140 VAMCs, only 100 or 71 percent were offering adult day health care in non-institutional settings.

By May 22, 2003, over one year later, GAO testified before the House Veterans' Affairs Subcommittee on Health that things had not improved and that veterans access to non-institutional LTC was still limited by service gaps and facility restrictions. GAO's assessment showed that for four of the six services, the majority of facilities either did not offer the service or did not provide access to all veterans living in the geographic service area. GAO summed up the problem nicely when it testified that " [f]aced with competing priorities and little guidance from headquarters, field officials have chosen to use available resources to address other priorities."

In the area of nursing home care, VA is equally recalcitrant in implementing the mandates of the Millennium Act. The Act required VA to maintain its in-house Nursing Home Care Unit (NHCU) bed capacity at the 1998 level of 13,391. This capacity has significantly eroded rather than been maintained. In 1999 there were 12,653 VA NHCU beds, 11,812 in 2000, 11,672 in 2001 and 11,969 in 2002. VA estimated it had 9,900 beds in 2003 and only 8,500 in 2004. VA claims that it cannot maintain both the mandated bed capacity and implement all the non-institutional programs required by the Millennium Act. Providing adequate inpatient LTC capacity is good policy and good medicine.

The American Legion believes that VA should take its responsibility to America's aging veterans seriously and provide the care mandated by Congress. Congress should do its part and provide adequate funding to VA to implement its mandates.

State Extended Care Facility Grants Program

Since 1984, nearly all planning for VA inpatient nursing home care has revolved around State Veterans Homes (SVHs) and contracts with public and private nursing homes. The reason for this is obvious; for fiscal year 2004 VA pays a per diem of $59.48 for each veteran it places in SVHs, compared to the $354.00 VA said it cost in FY 2002 to maintain a veteran for one day in its own NHCUs.

Under the provisions of Title 38, United States Code (U.S.C.), VA is authorized to make payments to states to assist in the construction and maintenance of SVHs. Today, there are 109 SVHs in 47 states with over 23,000 beds providing nursing home, hospital, and domiciliary care. The Grants for Construction of State Veterans Homes provides funding for 65 percent of the total cost of building new veterans homes and about 3,500 beds per year are planned for the next four years. VA has not been able to keep pace with the number of grant applications; and

currently there is over $120 million in unfunded new construction projects pending. Recognizing the growing long-term health care needs of older veterans, it is essential that the State Veterans Home Program be maintained as a viable and important alternative health care provider to the VA system.

The American Legion supports increasing the amount of authorized per diem payments to 50 percent for nursing home and domiciliary care provided to veterans in State Veterans Homes. The American Legion also supports the provision of prescription drugs and over-the-counter medications to State Homes Aid & Attendance patients, along with the payment of authorized per diem to State Veterans Homes. Additionally, VA should allow for full reimbursement of nursing home care to 70 percent service-connected veterans or higher, if the veteran resides in a State Veterans Home.

The American Legion recommends $124 Million for the State Extended Care Facility Grants Program in FY 2006.

ENVIRONMENTAL EXPOSURES

Agent Orange

This nation has a moral obligation to provide quality health care to all veterans. One of the top priorities of The American Legion has been to ensure that long overdue major epidemiological studies of Vietnam veterans who were exposed to the herbicide Agent Orange are carried out. In the early 1980's Congress held hearings on the need for such epidemiological studies. PL 96-151 directed VA to conduct an epidemiological study of long-term adverse health effects in veterans who served in Vietnam as a result of exposure to herbicides. VA was unable and unwilling to do the job; the responsibility was then passed to the Centers for Disease Control (CDC). In 1986, CDC also abandoned the project, asserting that a study could not be conducted based on available records.

The American Legion did not give up. Now, three separate panels of the National Academy of Sciences have agreed with The American Legion and concluded that CDC was wrong and that epidemiological studies based on DoD records are possible.

The latest Institute of Medicine (IOM) report is based on the research carried out by a Columbia University team, headed by Dr. Jeanne Mager Stellman, which has developed a powerful method for characterizing exposure to herbicides in Vietnam. The American Legion is proud to have collaborated in this research effort. The IOM has issued a report urgently recommending that epidemiological studies be undertaken, now that an accepted exposure methodology is available and The American Legion strongly endorses that report.

Congress must make sure that VA is directed to ensure that these urgently needed studies take place and are carried out by independent scientists with IOM participation. The studies require both funding and assurance of ready access to the military personnel records and histories, if this long overdue debt to our Vietnam veterans is ever to be paid.

Additionally, The American Legion is extremely concerned about the timely disclosure and release of all information by DOD on the use and testing of herbicides in locations other than Vietnam during the war. Over the years, The American Legion has represented veterans who claim to have been exposed to herbicides, such as Agent Orange, in places other than Vietnam. Without official acknowledgement by the government, proving such exposure was virtually impossible. Information has come to light in the last few years leaving no doubt that Agent Orange, and other herbicides contaminated with dioxin, were released in locations other than Vietnam. This information is slowly being disclosed by DOD and provided to VA.

In April 2001, officials from DOD briefed VA on the use of Agent Orange along the Korean demilitarized zone (DMZ) from April 1968 through July 1969. It was applied through hand spraying and by hand distribution of pelletized herbicides to defoliate the fields of fire between the front line defensive positions and the south barrier fence. The size of the treated area was a strip 151 miles long and up to 350 yards from the fence to north of the civilian control line. According to available records, the effects of the spraying were sometimes observed as far as 200 meters downwind. Original estimates projected as many as 80,000 troops were possibly exposed during this period. Although this number was later reduced to 12,056, DOD identified the units that were stationed along the DMZ during the period in which the spraying took place. This information was given to VA's Compensation and Pension Service, which in turn provided it to all 58 regional offices. VA Central Office has instructed its Regional Offices to concede exposure for veterans who served in the identified units during the period the spraying took place.

In January 2003, DOD provided VA with an inventory of documents containing brief descriptions of records of herbicides used at specific times and geographic locations outside of Vietnam. The information, unlike the information pertaining to the Korean DMZ, does not contain units' involved or individual identifying information. Also, according to VA, this information is incomplete, reflecting only 70 to 85 percent of herbicide use, testing and disposal locations outside of Vietnam. VA requested that DOD provide it with information regarding the units involved with herbicide operations or other information that may be useful to place veterans at sites where herbicide operations or testing was conducted.

Obtaining the most accurate information available concerning possible exposure is extremely important for the adjudication of herbicide-related disability claims of veterans claiming exposure outside of Vietnam. For herbicide-related disability claims, veterans who served in Vietnam during the period of January 9, 1962 to May 7, 1975 are presumed by law to have been exposed to Agent Orange. Veterans claiming exposure to herbicides outside of Vietnam are required to submit proof of actual exposure. This is why it is crucial that all information pertaining to herbicide use, testing, and disposal in locations other than Vietnam be released to VA in a timely manner. Congressional oversight is needed to ensure that additional information identifying involved personnel or units for the locations already known by VA is released by DOD as well as all relevant information pertaining to other locations that have yet to be identified. Locating this information and providing it to VA must be a priority.

Gulf War Illness

Hallmark legislation was enacted in 1994 to ensure compensation for Gulf War veterans suffering from unexplained illnesses. Although PL 103-446 looked good on paper, a 75 percent denial rate was the reality for sick Gulf War veterans seeking VA service connection for Gulf War-related undiagnosed illness. As a result, The American Legion supported legislation to amend Title 38 USC with the goal of correcting this problem.

Despite the enactment of the Veterans Education and Benefits Expansion Act of 2001 (PL 107-103), clarifying and expanding the definition of undiagnosed illness by including medically unexplained chronic multi-symptom illness, such as chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome, the denial rate for these claims remains very high. The restrictive nature of VA's final rule, published in the Federal Register on June 10, 2003, implementing the Gulf War provisions of PL 107-103 will likely reinforce this pattern. We urge both the House and Senate Veterans' Affairs Committees to conduct oversight of the Gulf War-related provisions of PL 107-103.

In January 2003, the Secretary of Veterans Affairs requested the IOM to review medical and scientific literature on the long-term health effects of sarin published since its initial report on sarin in September 2000. In its 2000 report, the IOM concluded that there was insufficient evidence to determine if an association exists between exposure to sarin, at levels too low to cause acute symptoms, and subsequent long-term adverse health effects. The IOM recommended that studies using laboratory animals be conducted to explore long-term health effects of acute short-term sarin exposure at levels that do not cause immediate acute symptoms. Subsequent to the September 2000 report, studies conducted by the U.S. Army Medical Research Institute of Chemical Defense found that low-level sarin exposure causes long-term health effects in animals. On August 20, 2004, IOM completed its review of all available peer-reviewed literature. Once again, IOM was unable to rule-out low level sarin exposure as a possible cause of long-term adverse health effects in Gulf War veterans. As in its 2000 report, IOM concluded that there is still insufficient/inadequate evidence to determine whether an association does or does not exist between sarin, at levels too low to cause immediate acute symptoms, and subsequent long-term adverse health effects.

Recent revelations involving the number of military personnel potentially exposed to sarin following the demolition of an Iraqi munitions storage complex in Khamisiyah, Iraq, in March 1991, makes this research imperative. On June 1, 2004, the Government Accountability Office (GAO) confirmed its June 2003 preliminary findings in a final report titled "Gulf War Illnesses: DOD'S Conclusions about U.S. Troops' Exposure Cannot Be Adequately Supported."

Due to the unreliability of DOD plume modeling, GAO determined that DOD's conclusions about the number of troops exposed are highly questionable. DOD models estimated that approximately 100,000 military personnel were potentially exposed to low-levels of nerve agent. According to GAO, as many as 350,000 U.S. military personnel may have been exposed to nerve agents in Iraq. GAO also concluded that given the weak data, further modeling efforts would not be any more accurate or helpful.

Given that GAO's investigation clearly invalidates DOD's modeling efforts as well as the usefulness of any future efforts, and the number of troops exposed to nerve agents is likely much greater than estimated by DOD, The American Legion urges that a presumption of exposure be granted for every service member in the region at the time of the demolition.

Atomic Veterans

Since the 1980s, claims by atomic veterans exposed to ionizing radiation for a radiogenic disease, which is not among those listed in Title 38, U.S.C. § 1112 (c)(2), have required an assessment to be made by the Defense Threat Reduction Agency (DTRA) as to nature and amount of the veteran's radiation dose(s). Under this guideline, when dose estimates provided are reported as a range of doses to which a veteran may have been exposed, exposure at the highest level of the dose range is presumed. From a practical standpoint, VA routinely denied the claims by many atomic veterans on the basis of dose estimates indicating minimal or very low-level radiation exposure.

As a result of the court decision of *National Association of Radiation Survivors (NARS) v. VA* and studies by GAO and others of the U.S.'s nuclear weapons test program, the accuracy and reliability of the assumptions underlying DTRA's dose estimate procedures have come into question. On May 8, 2003, the National Research Council's Committee to Review the DTRA Dose Reconstruction Program released its report. It confirmed the complaints of thousands of atomic veterans that DTRA's dose estimates have often been based on arbitrary assumptions resulting in underestimation of the actual radiation exposures. Based on a sampling of DTRA cases, it was found that existing documentation of the individual's dose reconstruction, in a large number of cases, was unsatisfactory and evidence of any quality control was absent. The committee concluded their report with a number of recommendations that would improve the dose reconstruction process of DTRA and VA's adjudication of radiation claims.

The American Legion was encouraged by the mandate for a study of the dose reconstruction program; nonetheless, we are concerned that the dose reconstruction program may still not be able to provide the type of information that is needed for atomic veterans to receive fair and proper decisions from VA. Congress should not ignore the National Research Council's findings and other reports, that dose estimates furnished VA by DTRA over the past fifty years have been flawed and have prejudiced the adjudication of the claims of tens of thousands of atomic veterans. It remains practically impossible for atomic veterans or their survivors to effectively challenge a DTRA dose estimate.

The American Legion believes that the dose reconstruction program should not continue. We urge the enactment of legislation to eliminate this provision in the claim of a veteran with a recognized radiogenic disease who was exposed to ionizing radiation during military service. VA's continued use of questionable radiation dose estimates has caused, and will continue to cause, the claims of thousands of radiation-exposed veterans to be denied.

Project 112 / Project SHAD

In June 2003, DOD completed its nearly three year investigation of Project 112, an extensive series of land based tests conducted between 1962 and 1973 to determine the vulnerability of U.S. military personnel to biological and chemical warfare attacks, and Operation Shipboard Hazard and Defense (SHAD), the shipboard portion of Project 112. On August 14, 2003, DOD submitted its report on the completion of its investigation on Project 112/SHAD to Congress.

The American Legion reiterates our concerns over the completion of the active investigation despite the promise that DOD's Deployment Health Support Directorate will continue to respond to questions and concerns regarding Project 112/SHAD and will investigate any new information brought to its attention in the future. DOD noted early in its investigation that some Project 112/SHAD files had been destroyed. DOD also noted that the term SHAD was not universally used to categorize the tests and it does not appear that DOD can guarantee that there were not other tests referred to by other names that were part of the same series.

According to DOD, only 50 of 134 planned tests were actually conducted. DOD identified 5,842 participants and forwarded the names to VA. When located, VA informs the veterans by letter of the test they participated in and encourages them to visit a VA medical facility if they have any health concerns. VA recently informed The American Legion that, as of August 6, 2004, it has sent notification letters to 2,991 veterans. Many veterans received multiple letters due to their participation in more than one test.

In 2002, VA requested IOM to conduct an epidemiological study to determine if veterans are suffering from long-term health problems related to their participation in Project 112/SHAD. This study is scheduled for completion in September 2005. The long-term health effects are still largely unknown and the completion of the IOM study is at least one more year down the road. In the meantime, ill veterans claiming service connection for disabilities they believe are related to their involvement in Project 112/SHAD are being denied compensation benefits. VA has been tracking Project 112/SHAD-related disability claims since July 2002. According to the Veterans Benefits Administration, (VBA), as of August 2004, 385 service connection claims had been received from veterans alleging disabilities due to exposures while participating in Project 112/SHAD. Of that number, 300 had been decided, only 17 of which were allowed. 85 claims were still pending, and 67 claims were granted for conditions not related to 112/SHAD exposures.

In the time it takes VA to locate and notify Project 112/SHAD participants identified by DOD, the number of ill veterans seeking health care and compensation from VA will increase. DOD may have ended its investigation but the ramifications of Project 112/SHAD will remain indefinitely. Thus, it is extremely important that Congress continue its oversight of this issue to ensure that Project 112/SHAD veterans are not abandoned.

Hepatitis C

Hepatitis C is an emerging national health crisis. There is an increased prevalence of Hepatitis C and associated health problems within the veteran population. According to VA, the rate of

veterans with Hepatitis C is at least three times higher than the rate of the general population, with Vietnam veterans, in particular, being a high-risk group. This problem is presenting a major challenge for VHA.

The American Legion was pleased with VA's initial response, in terms of their pro-active approach to Hepatitis C education, outreach, testing, and treatment efforts. However, in fiscal year 2003, citing the lack of sufficient funds to meet the increased demand for all types of VA care, VA seriously scaled back its Hepatitis C outreach and treatment programs. VA has, in fact, begun to discourage the testing of veterans who may be at risk for Hepatitis C and are even turning away some veterans who test positive, because they are not accepting new enrollments and the costs associated with current treatment regimens is so high. This policy is unacceptable.

Even though VHA is being forced to curtail many of its Hepatitis C initiatives, it is continuing internal education efforts directed at VHA health care providers and patients. It is continuing to develop data from ongoing screening of veterans' health records. To the extent possible, VHA is utilizing the latest treatment modalities, which has shown promising results. There are also a number of recently initiated research projects underway to learn more about the risk factors associated with this virus.

The American Legion believes that, in addition to its budgetary responsibilities, Congress has a legislative role in responding to the Hepatitis C challenge.

HOMELESS VETERANS

VA has estimated that there are at least 345,000 homeless veterans in America. Most homeless veterans today are single men; however, the number of single women with children has drastically increased within the last few years. Homeless female veterans tend to be younger, more likely to be married, and less likely to be employed. They are also more likely to suffer from serious psychiatric illness.

Approximately 40 percent of homeless veterans suffer from mental illness, and 80 percent have alcohol or other drug abuse problems. It cannot go unnoticed that the increase in homeless veterans coincides with the under-funding of VA health care, which resulted in the downsizing of inpatient mental health capabilities in VA hospitals across the country. Since 1996, VA has closed 64 percent of its psychiatric beds and 90 percent of its substance abuse beds. It is no surprise that many of these displaced patients end up in jail, or on the streets. The American Legion believes there should be a focus on the prevention of homelessness, not just measures to respond to it. Preventing it is the most important step to ending it.

The current Administration has vowed to end the scourge of homelessness within ten years. The clock is running on this commitment, yet words far exceed deeds. On any given night in this nation there are as many as 300,00 homeless veterans with as many as 600,000 homeless during the year. While less than nine percent of the nation's population are veterans, 34 percent of the nation's homeless are veterans and 75 percent are wartime veterans. H.R. 4248, The Homeless Veterans Assistance Reauthorization Act of 2004, would extend the authority of VA to make grants to assist eligible entities in establishing programs for homeless veterans. This bill

increases the appropriations available from $75 million to $100 million through fiscal year 2008. This equates to $287 per homeless veteran per year for the next four fiscal years, hardly an adequate intervention at the Federal level.

Homelessness in America is a travesty, and veterans' homelessness is disgraceful. Left unattended and forgotten, these men and women, who once proudly wore the uniforms of this nation's armed forces and defended her shores, are now wandering her streets in desperate need of medical and psychiatric attention and financial support. While there have been great strides in ending homelessness among America's veterans, there is much more that needs to be done. We must not forget them. The American Legion supports funding that will lead to the goal of ending homelessness in the next ten years.

MEDICAL SCHOOL AFFILIATIONS

VHA and its medical school affiliates have enjoyed a long-standing and exemplary relationship for nearly 60 years that has continued to thrive and evolve to the present day. Currently, there are 126 accredited medical schools in the United States. Of these, 107 have formal affiliation agreements with VA Medical Centers (VAMCs). More than 30,000 medical residents and 22,000 medical students receive a portion of their medical training in VA facilities annually. VA estimates that 70 percent of its physician workforce have university appointments. At some medical schools, 95 percent of medical staff at affiliated VAMCs have dual appointments.

VHA conducts the largest coordinated education and training program for health care professions in the nation and medical school affiliations allow VA to train new health professionals to meet the health care needs of veterans and the nation. Medical school affiliations have been a major factor in VA's ability to recruit and retain high quality physicians and to provide veterans access to the most advanced medical technology and cutting edge research; VHA research has made countless contributions to improve the quality of life for veterans and the general population.

The American Legion affirms its strong commitment and support for the mutually beneficial affiliations between VHA and the medical schools of this nation. VA medical school affiliates should be appropriately represented as a stakeholder on any national Task Force, Commission, or Committee established to deliberate on veterans' health care. Degradation of the affiliations combined with the nursing shortage and the current cap on J-1 visa physicians and the expected sharp decline in the number of volunteers in VAMCs could spell major staffing difficulties for the veterans' health care system.

MEDICAL AND PROSTHETICS RESEARCH

VA Medical and Prosthetic Research Service has a history of productivity in advancing medical knowledge and improving health care not only for veterans, but all Americans. VA research has led to the creation of the cardiac pacemaker, nicotine patch, and the Computerized Axial Tomography (CAT) scan, as well as other medical breakthroughs. Over 3800 VA physicians and scientists conduct more than 9,000 research projects each year involving more than 150,000 research subjects. The American Legion is impressed by the unprecedented cooperative work being done by VA and DOD on traumatic amputation rehabilitation and prosthetics research and

development. In November of last year, the two Departments met to discuss advances in this area, including the microprocessor based C-Leg, osseintegration, sharing of gait analysis and ergonomic data and computer assisted design and fitting of prosthetics. VA and DOD should establish a Joint Center of Excellence in this field.

The American Legion supports adequate funding for VA biomedical research activities, including basic research as well as bench-to-bedside projects. Congress and the Administration should encourage acceleration in the development and initiation of needed research on conditions that significantly affect veterans - such as prostate cancer, addictive disorders, trauma and wound healing, post-traumatic stress disorder, rehabilitation, and others - jointly with the Department of Defense (DoD), the National Institutes of Health (NIH), other Federal agencies, and academic institutions.

The American Legion recommends $ 445 million for Medical & Prosthetics Research in FY 2006.

VETERANS BENEFITS ADMINISTRATION

The Department of Veterans Affairs has a statutory responsibility to ensure the welfare of the nation's veterans, their families, and survivors. Each year, the 58 regional offices of the Veterans Benefits Administration (VBA) receive over 100,000 new and reopened benefits claims. A majority of these claims involve multiple issues that are legally and medically complex and time consuming to adjudicate. Whether a case is complex or simple, these offices are expected to develop and adjudicate veterans' and survivors' claims in a fair, legally proper, and timely manner.

Claims Backlog

Earlier this year, we expressed concern about the probable effect of a major cut back in regional office staffing slated for FY 2004 and a further smaller reduction proposed for FY 2005. It did not appear that the available staffing resources were going to be sufficient to handle the additional workload associated with legislation enacted by this Congress affording new benefit entitlements, along with liberalized VA policy on diseases related to Agent Orange and required support for DOD's Combat Related Special Compensation Program (CRSC). There has also been an influx of new claims for service connection, due to the fact that enrollment in VA's medical care system remains closed to some Category 8 disabled veterans. Much of the overall increased workload, however, stems directly from the required rework of tens of thousands of pending and previously decided cases, due to precedent decisions of both the United States Court of Appeals for Veterans Claims and the United States Court of Appeals for the Federal Circuit.

The Veterans' Claims Assistance Act of 2000 (VCAA), PL 106-475, was designed to overcome deficiencies in the claims adjudication process, improve the way VBA communicates with claimants, and the way in which claims were developed. The basic goal was to ensure that VA regional offices provided individuals essential information concerning their claim, so that they would know what evidence they were expected to submit and what evidence VA would try and obtain. This legislation was expected to result in claims that were more fully developed and

which could be adjudicated in a more expeditious and accurate manner. There was also an expectation that these improvements would increase claimant's satisfaction with the decision received and reduce the appeals workload for the Decision Review Officers and the Board of Veterans Appeals.

VBA has, over the last three years, begun aligning its policies and procedures to conform to the letter and intent of VCAA, and has directed most of the regional offices' time and effort toward reducing claims processing time and reducing the backlog of pending claims. Achievement of Secretary Principi's stated goal of 100 days to process a claim, on average, and a backlog of 250,000 pending claims by the end of fiscal year 2003 has been and continues to be VBA's number one priority. To fulfill mandated production quotas, regional office management and adjudicators have been put in the difficult and unenviable position of having to choose between deciding thousands of cases as quickly as possible or going through the more time consuming steps necessary to comply with VCAA and provide the claimant full due process.

In October 2003, Secretary Principi announced that the claims backlog had been reduced to the promised target level. Claims processing times were also trending down toward the 100-day goal and the error rate was improving. From VBA's perspective, these results showed that regional office service had improved dramatically. Part of Secretary Principi's promise was, once the backlog goal had been achieved, VBA would be able to shift time and attention to improving the quality of claims adjudication. However, experience has once again shown that "faster is not always better."

Unfortunately for thousands of veterans and their families, their rights under the VCAA have been subordinated to bureaucratic convenience for the sake of an arbitrary administrative goal. This persistent disregard of the law prompted thousands to file otherwise unnecessary appeals. Since judicial review of veterans' claims was enacted in 1988, of those cases appealed to the United States Court of Appeals for Veterans Claims (CAVC), the remand rate, historically, has been about fifty percent. In a series of precedent setting decisions by the CAVC and the United States Court of Appeals for the Federal Circuit, the courts have invalidated a number of longstanding VA policies and regulations because they were not consistent with the statute. In response to the these decisions, VBA, less than a month ago, provided the regional offices with revised templates for VCAA notices to conform to the directives of the court. The American Legion has not had an opportunity to evaluate the legal sufficiency of these new notices.

These court decisions immediately added thousands of cases to regional office pending workloads, since they require the review and reworking of tens of thousands of completed and pending claims. Between October 2003 and December 2003, the case backlog increased from 250,000 to 350,000. From January to August 2004, the number of pending claims has been reduced only by some 25,000 cases. However, over the same period, the number of appeals pending in the regional offices has grown by 20,000 cases. Data on regional office performance appear to contradict VBA's description of improvements in service to veterans.

Lack of Quality Decision Making in VBA

The adequacy of regional office staffing has as much to do with the actual number of personnel as it does with the level of training and competency of the adjudication staff. VA's FY 2005 budget request notes the fact that VBA has lost much of its institutional knowledge base over the past four years, due to the retirement of many of its 30-plus year employees. Retirements among this group are expected to continue at a significant rate in 2005. As a result, staffing at most regional offices is now made up mostly of trainees, with less than five years of experience. Over this same period, as regional office workload demands escalated, these trainees have been put into production units as soon as they completed their basic training.

The American Legion's visits to regional offices have found that, frequently, there have been too few supervisors or inexperienced supervisors to provide trainees necessary mentoring, training, and quality assurance. In addition, at many stations, ongoing training for the new hires as well as the more experienced staff would be postponed or suspended, so as to focus maximum effort on production. Despite the fact that VBA's policy of "production first" has resulted in many more veterans getting faster action on their claims, the downside has been that tens of thousands of cases have been prematurely and arbitrarily denied. As a consequence, the appeals burden at the regional offices, the Board and the Appeals Management Center (AMC) continues to grow. What must also be kept in mind is that there is a disabled veteran, most often with a family, behind each one of these appeals, who has been fighting the VA system for a year, two years, or more to get what he or she feels they are rightfully entitled to.

The American Legion was very disturbed by information presented at the recent VBA Leadership Conference about regional office adjudicators' job performance. VBA had two groups of Veterans Service Representatives (VSRs) take a job skill certification test. There were 650 individuals tested. They were GS 10 and GS 11 with three to five years of regional office claims experience and were considered to be proficient workers. It was, therefore, very disconcerting to learn that only 25 percent of the GS 10s and 29 percent of the GS 11s passed the open book test. If these individuals are supposed to be VBA's best and brightest adjudicators, it is little wonder that appeal workload continues to rise, the combined overturn rate at the Board of Veterans Appeals is now up to 75 percent. From these results, it appears that, despite having spent millions on its adjudicator-training program, this effort has not succeeded in correcting the many problems that contribute to poor quality decision-making and create unnecessary appellate work. Rather than providing a solution to the problem, the deficiencies in training and the lack of effective quality assurance continue to fuel the growing backlogs.

Appeals Management Center

As a result of a successful legal challenge to the establishment of a unit at the Board of Veterans' Appeals (Board or BVA) to undertake needed development of appeal cases, VBA established the AMC. Its purpose is to provide more expeditious action on remands and also to relieve the regional offices of the workload burden associated with remands. The AMC basically functions as a national regional office for this type of case. It undertakes the additional development of evidence specified by the Board and readjudicates the claim. This unit, with a staff of 82 FTE, is in danger of being overwhelmed by a growing volume of cases. Initially, 16,484 cases were inherited from the now-defunct BVA development unit and, currently, the AMC has a total of 22,040 remands under development.

While the AMC is an admirable attempt by VBA to improve service to veterans, it does nothing to address the problems underlying the continued rise in the number of appeals and remands by the Board of Veterans Appeals. In our view, the very necessity of the AMC's existence begs the question – why hasn't VBA mandated the regional offices to correct their own mistakes?

This new super regional office is now responsible for correcting errors that the regional offices were unwilling or unable to do. However, the AMC has no authority to prevent the same type of error, which prompted the appeal and remand, from occurring again. It is worth noting that regional offices did not receive any work credit for remand actions. This should have been an incentive for local management to try and improve decision-making and avoid appeals and potential remands. Experience has shown just the opposite.

Since production work on new claims were the highest priority and there was no work credit for remands, many regional offices simply ignored their appellate workload with remands pending for two and three years. Now, there is still no clear incentive for the regional offices to improve quality. They are continuing to forward new cases to the Board where almost sixty percent are being remanded to the AMC. VBA must ensure that the regional offices are held accountable for the poor quality of initial decision-making and development of appeals and not allow them to shift the workload onto the Board of Veterans Appeals and, ultimately, the AMC.

Board of Veterans' Appeals

The BVA is a separate entity within VA. Its responsibility is to render a final decision on the propriety of a regional office decision. If the Board determines a final decision cannot be made on a case due to inadequate or incomplete development, including lack of due process, it has the authority to remand the case back to agency of original jurisdiction, which now includes the AMC, for additional required development and readjudication.

In acknowledgement of the longstanding and unresolved problem with the quality of regional office decision making, VA's FY 2005 Budget Submission states, "Historically, the VA appellate program has been a high volume activity." We share the view that regional office appeals and dispositions by the Board are a direct reflection of the level of claimant satisfaction or dissatisfaction with and confidence or lack thereof in the fairness and propriety of regional office adjudication. It is, therefore, painfully obvious that the level of dissatisfaction is substantial and growing, in view of the increasing number of new appeals coming into the system.

Currently, there are over 149,000 cases appellate status in the regional offices with over 129,000 requiring some type of further adjudicative action. A year previous, there were approximately 20,000 fewer pending appeals. At the present time, it is taking over 700 days for the regional offices to complete action on a pending appeal and forward it to the Board. Even though the Board's current average processing time is 236 days, which is 81 days more than the 2004 cycle time goal of 155 days, we do not believe there is an urgent or overriding need for any substantial increase in staffing. The amount of time it is taking to process an appeal should not be the

driving factor in decisions about the adequacy of the Board's staffing. The American Legion is more concerned that the Board's decisions are fair and proper and made in a timely manner.

Of equal concern is the fact that, in the first nine months of FY 2004, the Board issued approximately 32,000 decisions and, of these, the regional offices' decisions have been affirmed or upheld in only 22.9 percent of the cases. The Board overturned the regional offices' decisions completely in 16.9 percent of the cases and remanded 58.5 percent appeals to the AMC for additional development and readjudication. The quality of regional office adjudication is totally unacceptable. It represents a tremendous waste of Federal government resources – time, effort, and taxpayers' money.

To ensure VA and VBA are meeting their responsibilities; The American Legion strongly believes that Congress must scrutinize VBA's budget requests more closely. Given current and projected future workload demands, regional offices clearly will need more rather than fewer personnel and The American Legion is ready to support additional staffing. However, VBA must be required to provide better justification for the resources it says are needed to carry out its mission and, in particular, how it intends to improve the level of adjudicator training, job competency, and quality assurance.

Combat Related Special Compensation (CRSC) Program

For those veterans who are receiving military retired pay based on 20 years or more of active, honorable military service, PL 108-136, the Defense Authorization Act for fiscal year 2004, partially removed the statutory bar to the concurrent receipt of VA disability compensation and military retired pay. Under this program, VA provides DOD with information concerning a retiree/veteran's service connected disability and identifies those that qualify as "combat-related", which includes those sustained in armed conflict, including PTSD, Type II diabetes for those exposed Agent Orange, as well as injuries incurred during hazardous duty or training exercises. Those rated totally disabled based on individual unemployability (IU) are also eligible for CRSC, if all of the service-connected conditions are "combat related."

There is, however, a problem where the rating of individual unemployability is based on a combination of combat-related and noncombat-related service connected disabilities. For example, if a retiree/veteran has an IU rating from VA, based on an evaluation of 60 percent for combat-related gunshot wounds and 20 percent for a service connected noncombat-related respiratory condition, DOD will only pay CRSC based on the 60 percent combat-related disability. We believe VA and VBA, in particular, needs to address this problem, since a number of disabled retiree/veterans are not receiving the full amount of CRSC that they are entitled to. This problem can be easily remedied, if VBA will issue instructions to the regional offices requiring a special rating for CRSC purposes on the issue of whether the combat-related disability alone renders the individual in question unemployable. The American Legion would welcome the Committees' support for such action by VBA to ensure those who have served and sacrificed for this nation receive the full measure of benefits that Congress intended.

GI BILL EDUCATIONAL BENEFITS

The American Legion commends the 108th Congress for its actions to improve the current Montgomery GI Bill (MGIB). A stronger MGIB is necessary to provide the nation with the caliber of individuals needed in today's Armed Forces. The American Legion appreciates the efforts that this Congress has made to address the overall recruitment needs of the Armed Forces and to focus on the current and future educational requirements of the All-Volunteer Force.

Over 96 percent of recruits currently sign up for the MGIB and pay $1,200 out of their first year's pay to guarantee eligibility. However, only one-half of these military personnel use any of the current Montgomery GI Bill benefits. This we believe is directly related to the fact that current GI Bill benefits have not kept pace with the increasing cost of education. Costs for attending the average four-year public institution, as a commuter student during the 1999-2000 academic year was nearly $9,000. On October 1, 2004, the basic monthly rate of reimbursement under MGIB will be raised to $1,004 per month for a successful four-year enlistment and $816 for an individual whose initial active duty obligation was less than three years. The current educational assistance allowance for persons training full-time under the MGIB – Selected Reserve is $282 per month.

The Servicemen's Readjustment Act of 1944, the original GI Bill, provided millions of members of the Armed Forces an opportunity to seek higher education. Many of these individuals may not have been afforded this opportunity without the generous provisions of that act. Consequently, these former service members made a substantial contribution not only to their own careers, but also to the economic well being of the country. Of the 15.6 million veterans eligible, 7.8 million took advantage of the educational and training provisions of the original GI Bill. Between 1944 and 1956, when the original GI Bill ended, the total educational cost of the World War II bill was $14.5 billion. The Department of Labor estimates that the government actually made a profit, because veterans who had graduated from college generally earned higher salaries and, therefore, paid more taxes.

Today, a similar concept applies. The educational benefits provided to members of the Armed Forces must be sufficiently generous to have an impact. The individuals who use MGIB educational benefits are not only improving their career potential, but also, making a greater contribution to their community, state, and nation.

The American Legion recommends the following improvements to the current MGIB:

- The dollar amount of the entitlement should be indexed to the average cost of a college education including tuition, fees, textbooks, and other supplies for a commuter student at an accredited university, college, or trade school for which they qualify;
- The educational cost index should be reviewed and adjusted annually;
- A monthly tax-free subsistence allowance indexed for inflation must be part of the educational assistance package;
- Enrollment in the MGIB shall be automatic upon enlistment; however; benefits will not be awarded unless eligibility criteria have been met;
- The current military payroll deduction ($1,200) requirement for enrollment in MGIB must be terminated;

- If a veteran enrolled in the MGIB acquired educational loans prior to enlisting in the Armed Forces, MGIB benefits may be used to repay those loans;
- If a veteran enrolled in MGIB becomes eligible for training and rehabilitation under Chapter 31, of Title 38, United States Code, the veteran shall not receive less educational benefits than otherwise eligible to receive under MGIB;
- A veteran may request an accelerated payment of all monthly educational benefits upon meeting the criteria for eligibility for MGIB financial payments, with the payment provided directly to the educational institution;
- Separating service members and veterans seeking a license, credential, or to start their own business must be able to use MGIB educational benefits to pay for the cost of taking any written or practical test or other measuring device;
- Eligible veterans shall have 10 years after discharge to utilize MGIB educational benefits; and
- Eligible members of the Select Reserves, who qualify for MGIB educational benefits shall receive not more than half of the tuition assistance and subsistence allowance payable under the MGIB and have up to 5 years from their date of separation to use MGIB educational benefits.

HOME LOAN GUARANTY PROGRAM

The American Legion believes that the current limit of VA Home Loan Guarantee of $252,500 should be raised to $300,000 and that higher limits be established for areas of the country where justified by prevailing real estate market conditions. In San Francisco, California, in 2002, the median price of a home was $482,300, an actual decrease of .3 percent from 2001. In Boston, Massachusetts, the median price of a home was $358,000; in the New York City Metro area, 285,600; and here in Washington D.C., the median home cost $229,100 in 2002, up 19.8 percent from $183,700 in 2001. Clearly, in these cities, the difference between many veterans being able to secure financing for a decent home for his or her family and being shut out of the market is due to the inadequate levels of the VA Home Loan Guarantee.

Additionally, The American Legion supports the recognition of VA Home Loan Guaranty benefits in cases where both members of a married couple are eligible for the benefit. If both members are eligible to receive the benefit, both members should be allowed to use the benefit.

NATIONAL CEMETERY ADMINISTRATION

The National Cemetery Administration (NCA) is charged with meeting the interment needs of the nation's veterans and their dependents. NCA is striving to meet its accessibility goal of 90 percent of all veterans living within 75 miles of open national or state Veterans cemeteries. There are approximately 14,200 acres within established installations in NCA. Just over half are undeveloped and, with available gravesites in developed acreage, have the potential to provide more than 3.6 million gravesites. More than 301,050 full-casket gravesites, 58,500 in-ground gravesites for cremated remains, and 37,900 columbarium niches are available in already developed acreage in our 120 national cemeteries.

National Cemetery Expansion

The NCA's budget proposal totaled $454.41 million and 1,779 FTE for Fiscal Year (FY) 2005. Of the total outlay projected for FY 2005, $180.2 million is for burial benefits, $148.9 million is for National Cemetery operations and maintenance and $31.2 million is for administrative expenses. The FY 2005 outlay proposal earmarks $81 million for major construction, a 45 percent increase over FY 2004 estimates. This reflects the cemetery construction mandated by The Veterans Millennium Health Care and Benefits Act, PL 106-117, which required NCA to establish six new National Cemeteries. The first, Fort Sill, opened in 2001 under the fast-track program, while the remaining five, Atlanta, Detroit, South Florida, Pittsburgh and Sacramento are in various stages of completion.

The American Legion supported PL 108-109, the National Cemetery Expansion Act of 2003 authorizing VA to establish new national cemeteries to serve veterans in the areas of Bakersfield, Calif.; Birmingham, Ala.; Jacksonville, Fla.; Sarasota County, Fla.; southeastern Pennsylvania; and Columbia-Greenville, S.C. All six areas have veteran populations exceeding 170,000, which is the threshold VA has established for new national cemeteries.

Congress must provide sufficient major construction appropriations to permit NCA to accomplish its stated goal of ensuring that burial in a national or state cemetery is a realistic option by locating cemeteries within 75 miles of 90 percent of eligible veterans.

National Shrine Commitment

Maintaining cemeteries as National Shrines is one of NCA's top priorities. This commitment involves raising, realigning and cleaning headstones and markers to renovate gravesites. The work that has been done so far has been outstanding; however, adequate funding is key to maintaining this very important commitment. At the rate that Congress is funding this work, it will take twenty-eight years to complete. The American Legion supports the Under Secretary for Memorial Affairs in his goal of completing the NCA's National Shrine Commitment in five years. This Commitment includes the establishment of standards of appearance for national cemeteries that are equal to the standards of the finest cemeteries in the world. Operations, maintenance and renovation funding must be increased to reflect the true requirements of the NCA to fulfill this Commitment.

The American Legion recommends $156 million for the National Cemetery Administration in FY 2006.

State Cemetery Grant Program

The FY 2005 budget requested $32 million for State Veterans Cemetery Grant Program. This is a "no-year money" and so any monies not spent in the previous fiscal year can be carried over into the next fiscal year. This program is not intended to replace National Cemeteries, but to complement them. Grants for state-owned and operated cemeteries can be used to establish, expand and improve on existing cemeteries. Currently there are 48 operating state cemeteries

around the country in 26 states. In FY 2003, NCA supported State cemeteries provided more than 18,180 interments.

Since NCA concentrates its construction resources on large metropolitan areas, it is unlikely that new national cemeteries will be constructed in all states. Therefore, individual states are encouraged to pursue applications for the State Cemetery Grants Program. Fiscal commitment from the state is essential to keep the operation of the cemetery on track. NCA estimates it takes about $300,000 a year to operate a state cemetery.

The American Legion recommends $40 million for the State Cemetery Grants Program in FY 2006.

Burial Benefits

The American Legion supports restoration of a veteran's burial allowance for wartime veterans, along with restoration of the pre-1990 Omnibus Budget Reconciliation Act criteria to provide eligibility for a government furnished headstone or marker allowance and restoration and increase of the burial plot allowance from $300 to $600.

The American Legion supports increasing the burial allowance from $330 to $1135 for compensably service connected and indigent veterans and $3712 from $2000 for veterans who die of a service-connected condition. This legislation would restore the intent of Congress to pay 22 percent and 76 percent, respectively, of the cost of an average funeral and would tie the allowances to the Consumer Price Index, thereby eliminating the need for periodic legislative increases.

The American Legion opposes any attempt to collect "User Fees" for burials in any national or state veterans' cemetery. The American Legion supports action to provide that when an eligible veteran dies in a state veterans hospital or nursing home, VA shall pay for the cost of transporting the remains to the place of burial as determined by VA.

DEPARTMENT OF LABOR VETERANS' EMPLOYMENT AND TRAINING PROGRAMS (VETS)

The mission of VETS is to promote the economic security of America's veterans. This stated mission is executed by assisting veterans in finding meaningful employment. The American Legion views the VETS program as one of the best-kept secrets in the Federal government. It is comprised of many dedicated individuals who struggle to maintain a quality program without substantial funding and staffing increases.

Annually, DOD discharges approximately 250,000 service members. Recently separated service personnel are likely to seek immediate employment or are preparing to continue their formal or vocational education. In order for the VETS program to assist these veterans to achieve their goals, it needs to:

- Improve by expanding its outreach efforts with creative initiatives designed to improve employment and training services for veterans.
- Provide employers with a labor pool of quality applicants with marketable and transferable job skills.
- Provide information on identifying military occupations that require licenses, certificates or other credentials at the local, state, or national levels.
- Eliminate barriers to recently separated service personnel and assists in the transition from military service to the civilian labor market.
- Strive to be a proactive agent between the business and veterans' communities in order to provide greater employment opportunities for veterans.

The American Legion believes staffing levels for Disabled Veterans' Outreach Program (DVOP) specialists and Local Veterans' Employment Representatives (LVERs) should match the needs of the veteran community in each state and not be based solely on the fiscal needs of the state government. Such services will continue to be crucial as today's active duty service members, especially those returning from combat in Iraq and Afghanistan, transition into the civilian world. Education and vocational training and employment opportunities will enable these veterans to succeed in their future endeavors. Adequate funding will allow the programs to increase staffing to provide comprehensive case management job assistance to disabled and other eligible veterans.

Title 38 U.S.C. § 4103A requires that all DVOP specialists shall be qualified veterans and that preference be given to qualified disabled veterans in appointment to DVOP specialist positions. Title 38 U.S.C. § 4104(a)(4) states: "[I]n the appointment of local veterans' employment representatives on or after July 1, 1988, preference shall be given to qualified eligible veterans or eligible persons. Preference shall be accorded first to qualified service-connected disabled veterans; then, if no such disabled veteran is available, to qualified eligible veterans; and, if no such eligible veteran is available, then to qualified eligible persons." The American Legion believes that the military experience is essential to understanding the unique needs of the veteran and that all LVERs, as well as all DVOPs, should be veterans

The American Legion recommends a funding level of $339 million for the Veterans' Employment and Training Service in fiscal year 2006.

Additionally, The American Legion recommends adequate funding for the National Veterans Training Institute (NVTI) budget. The NVTI provides standardized training for all veterans employment advocates in an array of employment and training functions.

The American Legion urges the reinstatement of the Service Members Occupational Conversion and Training Act (SMOCTA). SMOCTA was developed as a transitional tool designed to provide job training and employment to eligible veterans discharged after August 1, 1990. Veterans eligible for assistance under SMOCTA were those with a primary or secondary military occupational specialty that DOD has determined is not readily transferable to the civilian workforce; or those veterans with a service connected disability rating of 30 percent or greater.

Eligible veterans receive valuable job training and employment services through civilian employers that built upon the knowledge and job skills the veterans acquired while serving in the military. This program not only improved employment opportunities for transitioning service members, but also enabled the federal dollars invested in education and training for active duty service members to be reinvested in the national job market by facilitating the transfer of skills from military service to the civilian workforce.

The American Legion strongly opposes any attempt to move VETS to VA. The Department of Labor (DoL) is the nation's leading agency for job placement, vocational training, job development, and vocational counseling. Due to the significant barriers to employment experienced by many veterans, VETS was established to provide eligible veterans with the services being provided to job ready Americans. Working with the local employment service offices, VETS gave eligible veterans the personalized assistance needed to enhance the transition into the civilian workforce. VA has very limited experience in the critical areas of job placement, vocational training, job development, and vocational counseling through its Vocational Rehabilitation Program.

FILIPINO VETERANS' BENEFITS

The American Legion believes that the time has come to extend full recognition and benefits to all veterans, American or Filipino, who were part of the defense of the Philippine Islands during World War II. The Department of Veterans Affairs, in VETPOP2001 revised, estimated that there were 60,000 surviving Filipino veterans who are classified as Philippine Commonwealth Army, Recognized Guerrilla and New Philippine Scouts veterans, of whom 45,000 reside permanently in the Philippines and 15,000 reside permanently in the U.S.

Of the 45,000 residing in the Philippines, 41,000 do not receive any compensation or pension benefit from VA, and most are sickly, over 70 years old and live below the poverty level. Those veterans living in the Philippines currently receive only 50 cents on the dollar as compensation for their service connected conditions. Veterans of those groups who live in the United States and members of the Regular Commonwealth Army living in the Philippines receive their full entitlement.

The current policy has created a virtual caste system of first and second-class U.S. veterans in the Philippines. These veterans fought, were wounded, became ill, became prisoners of war, were subject to torture, deprivation and starvation and many died in the service of the Armed Forces of the Unites States at the same rates as regular U.S. soldiers, sailors and Marines who were isolated on those islands during the Japanese occupation.

Filipino veterans have recently been somewhat successful in incrementally increasing benefits to parity with other U.S. veterans; however, the exclusion of these veterans from full benefits remains a fundamental unfairness in the law that has stood for too many years. As the numbers of these deserving veterans quickly dwindle, Congress has little time to redress this injustice.

SUMMARY

Messrs. Chairmen and Members of these Committees, The American Legion appreciates the strong relationship we have developed with both Committees. With increasing military commitments worldwide, it is important that we work together to ensure that the services and programs offered through VA are available to the new generation of American service members who will soon return home. You have the power to ensure that their sacrifices are indeed honored with the thanks of a grateful nation.

The American Legion is fully committed to working with each of you to ensure that America's veterans receive the entitlements they have earned. Whether it is improved accessibility to health care, timely adjudication of disability claims, improved educational benefits or employment services, each and every aspect of these programs touches veterans from every generation. Together we can ensure that these programs remain productive, viable options for the men and women who have chosen to answer the nation's call to arms.

Thank you for allowing me the opportunity to appear before you today.